

FILED NOV 19 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42452**
Registrar's No. **10745**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 10745	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission!) a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4150 Bingham Ave				e. STREET ADDRESS (If rural, give location) 4150 Bingham Ave			
3. NAME OF DECEASED (Type or Print) a. (First) CAROLINE		b. (Middle) J.		c. (Last) PETRY		4. DATE OF DEATH (Month) (Day) (Year) 11-9-1957	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 4-2-1902	
9. AGE (In years last birthday) 55		10. IF UNDER 1 YEAR Months _____ Days _____		10. IF UNDER 14 HRS. Hours _____ Mins. _____		11. BIRTHPLACE (City and State or Foreign Country) Missouri	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY _____			
11. CITIZEN OF WHAT COUNTRY? U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME John Schulte				13b. MOTHER'S MAIDEN NAME Augusta Buhse			
14. NAME OF HUSBAND/OR WIFE Julius F. Petry				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT'S SIGNATURE OR NAME Julius F. Petry			
18. ADDRESS 4150 Bingham Ave				19. ADDRESS 4150 Bingham Ave			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma pancreas c metastases ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) metastases DUE TO (c) Arteriosclerotic Heart Disease			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION 157x			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				21. ACCIDENT SUICIDE HOMICIDE (Specify) _____			
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____				21b. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR? _____				22. I hereby certify that I attended the deceased from Oct 7, 1953 to Nov 9, 1957 , that I last saw the deceased alive on Nov 9, 1957 and that death occurred at 11:57 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE Joseph E. Carney M.D.				23b. ADDRESS 906 Olive			
23c. DATE SIGNED 11-12-57				24. BURIAL, CREMATION, REMOVAL (Specify) Burial			
24b. DATE 11-13-1957				24c. NAME OF CEMETERY OR CREMATORY St. Peter and Paul			
24d. LOCATION (City, town, or county) (State) 7030 Gravois Ave				DATE REC'D BY LOCAL REG. NOV 12 57			
REGISTRAR'S SIGNATURE J. Earl Smith M.D.				FURNERAL DIRECTOR'S SIGNATURE Biengden Bros			
ADDRESS 6409 Gravois Ave				(Licensed Embalmer's Statement on Reverse Side)			

Dr. John Carney Frisco Bldg

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 4343

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.